

**DEPARTMENT OF VETERANS AFFAIRS - ANALYSIS OF  
MEDICAL MALPRACTICE CLAIMS - AN INITIAL REPORT**  
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The Department of Veterans Affairs (VA) operates one of the nation's largest medical systems. It is composed of 172 hospitals and more than 350 outpatient facilities. Teaching affiliations are maintained with 160 medical and dental schools nationwide. Professional providers within the VA include 7,324 full-time and 5,921 part-time staff physicians, 15,020 resident physicians, and 39,355 nurses.<sup>1,2</sup> In FY 1991, there were 951,112 inpatients and 21,932,426 outpatients treated at VA medical facilities.

### **VA TORT CLAIM INFORMATION SYSTEM**

As with other large medical systems, recent years have witnessed increasing attention directed toward the VA medical malpractice claims experience. In 1985, the VA Office of the Inspector General (OIG) released a report recommending that the VA Department of Medicine and Surgery perform an extensive analysis of those medical conditions and surgical procedures that had resulted in malpractice claims. In March 1987, a subsequent OIG audit noted that the VA had initiated a number of monitors regarding medical malpractice claims but, due to resource constraints, a comprehensive analysis of the characteristics of those claims had not yet been accomplished. In March 1988, at a Congressional oversight committee hearing, Senator John Glenn (D-Ohio) emphasized the importance of utilizing data generated from the analysis of malpractice claims for purposes of monitoring and improving VA medical care. At that time, the Office of the General Counsel of the VA and that of the Medical Inspector combined efforts to develop the Tort Claims Information System (TCIS).<sup>3</sup>

Initial procedures regarding TCIS were promulgated in August 1988.<sup>4</sup> Each VA medical center was directed to forward reports regarding any medical malpractice claim filed to the Office of the Medical Inspector. These reports were to include a summary of the incident involved, identification of responsible providers, relevant medical records, and available quality assurance documents. The Medical Inspector's staff was to collect these reports, conduct individual case reviews, and assemble aggregate malpractice data for the respective medical centers and for the system, on a regional and a national basis.

At first, these case reviews were restricted to the analysis of malpractice claims that were legally closed or finalized because there was no statutory protection for the confidentiality of the peer review information contained within submitted reports. By May 1990, when TCIS gained statutory protection for that confidentiality as medical quality assurance (38 U.S.C. § 3301), 1700 legally finalized malpractice cases had been reviewed. Thereafter, VA medical facilities were directed to report malpractice claims filed and to include a completed peer review analysis of each case.<sup>5</sup>

Responsibility for TCIS within the VA was transferred from the Office of the Medical Inspector to that of the Associate Deputy Chief Medical Director in November 1990. Tort claims analysis was later deemed an

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inherent risk management activity within the agency's quality assurance system, and its responsibility was transferred in March 1991 to the Office of the Associate Chief Medical Director for Quality Management.

In 1992, the VA entered into a sharing agreement, regarding analysis of medical malpractice claims experience, with the Department of Legal Medicine (DLM) at the Armed Forces Institute of Pathology. DLM has engaged in medicolegal consultation, research and education within DoD for more than two decades. DLM maintains a registry of all administrative claims, along with relevant medical and legal documents, that concern allegations of negligence in Department of Defense (DoD) medical treatment facilities. These claims are subjected to a series of trends analyses. DLM also collates and analyzes other risk management data submitted electronically by the Offices of the Surgeons General of the military services and provides regular summary reports regarding that information to those contributors and to the Assistant Secretary of Defense - Health Affairs (ASD-HA). DLM has been tasked by ASD-HA to conduct these recurring analyses, along with other research regarding those submissions, to assist that office in the derivation and implementation of policies calculated to improve the quality of health care within DoD.<sup>6</sup>

The sharing agreement of June 1992 calls for DLM to provide the VA with similar data analyses and educational programs. Under the agreement, DLM analyzes the nationwide VA tort claims experience, collates data, and provides periodic reports to assist the VA in identifying any high risk practice areas and developing responsive, remedial quality improvement endeavors. To assist the reader in understanding the VA Tort Claim Information System, certain terms and procedures that control the pursuit of a medical malpractice claim against the United States government must be delineated. A petitioner initiates this process by filing a claim, utilizing a designated federal standard form (SF-95), with a legal representative of the federal agency involved. For claims involving the VA, an SF-95 is filed with the respective District Counsel. By regulation, claims remain in an administrative phase for six months, while the federal agency involved is charged with investigating the allegations and attempting a final resolution, either by formal denial or settlement. If the claim is officially denied, the petitioner may seek administrative reconsideration by the VA General Counsel. Alternately, the claimant may then elect to file suit against the government in United States District Court. As a named defendant, the federal government is represented in litigation by the U.S. Department of Justice, and trial or settlement thereafter is ultimately controlled by that agency. It should be noted that if the six month administrative phase of this process passes with no federal agency action, neither settlement nor denial, the petitioner is permitted to consider the claim denied and elect to file suit.

## **TCIS DATA**

As originally implemented, all malpractice claims filed against the VA were entered into TCIS. The entry for each claim was later updated, without creating a second record, if litigation ensued. Information was extracted from every claim, and data was entered into a computer protocol. Database entries from VA District Counsel offices across the nation included the following: 1) claimant's name; 2) injured person's name; 3) VA medical facility; 4) VA legal office; 5) court; 6) amount claimed; 7) fiscal year claim opened; 8) disposition; 9) payment or closure date; 10) amount paid; 11) date filed; 12) location of injury; 13) incident date; 14) hospital service; 15) specialty; 16) alleged negligence code; 17) alleged injury; 18) injury severity; and 19) description of alleged negligence

VA District Counsel offices also submitted patient information concerning service-connected injury or service-connected disability.

Each VA medical facility submitted a Peer Review Analysis and data entries regarding providers. Provider names, specialties, and assignment categorization within VA were included. Entries derived from

peer review included whether: 1) claim incident was preventable; 2) death was preventable; 3) negligence affected clinical outcome; 4) clinical outcome represented normal risk; 5) standard of care was met; 6) patient incident report was indicated; 7) on site investigation was required

Further determinations of as many as five separate errors within the provision of the medical care reviewed could be amended to this section of the report, and an opportunity for comment was provided.

In May 1992, the Offices of the VA Associate Chief Medical Director for Quality Management, the VA General Counsel and DLM surveyed selected data within TCIS. DLM evaluated only that portion of the TCIS entered by local District Counsel offices.

Tables published within this article derive from entries in the TCIS database. The totals reported in different tables vary, and this may simply result from clerical errors. More likely, as has been encountered in the analysis of DoD malpractice data, this variance may reflect the inherent difficulty in securing a complete collection of data from both medical and legal sources within a large system.<sup>7</sup>

As of the survey date, TCIS contained entries regarding 3,796 malpractice claims. When TCIS began in 1988, only active or recently closed cases were added to the database. The VA has annually received approximately 700 claims since 1989, when TCIS became fully operational. This experience is similar to that of DoD, which maintains 168 medical treatment facilities world-wide and receives approximately 900 claims per year.<sup>8</sup>

Table 1 indicates the status of 3,796 malpractice cases within TCIS. Approximately 30 percent of the cases are "open", i.e., not presently resolved. Of open cases, the majority (739 or 62 percent of 1,195) are administrative claims managed by different District Counsel offices. The remainder are either in litigation or their responsibility has been transferred to the VA General Counsel.

Approximately 70 percent of the TCIS entries regard malpractice disputes that were closed either in the administrative or the litigation phase. The majority of these, 1,478 cases, were closed by District Counsel offices. Within the 3,796 cases reported in the database, 1,029 or 27 percent had been closed by denial. District Counsel offices settled 449 or 12 percent of the cases. The VA General Counsel settled 157 (4 percent) of the cases reported within TCIS and had denied 88 (2 percent).

The database includes entries regarding 828 cases (22 percent) that proceeded to litigation. United States Attorney offices settled 477 (12 percent) of these disputes. Of those that were tried, there were 108 (3 percent) that resulted in judgments for the United States and 64 (2 percent) with judgments for the

CASE STATUS N=3796		
STATUS	NUMBER	PERCENT
<b>I. OPEN CASES (1195 or 31%)</b>		
Administrative Claim	739	19
Litigation	341	9
Transfer to General Counsel	64	2
Transfer to General Counsel (Reconsideration)	51	1
<b>TOTAL OPEN CASES</b>	<b>1195</b>	<b>31</b>
<b>II. CLOSED CASES (2601 or 69%)</b>		
DISTRICT COUNSEL (1478 or 39%)		
Denial	1029	27
Settlement	449	12
GENERAL COUNSEL (245 or 6%)		
Denial	88	2
Settlement	157	4
LITIGATION (828 or 22%)		
Suit Dismissed	179	5
Suit Settled	477	1
Judgment for Plaintiff	64	2
Judgment for Government	108	3
OTHER	50	2
<b>TOTAL CLOSED CASES</b>	<b>2601</b>	<b>69</b>

**TABLE 1**

plaintiff. Litigation of these cases was presided over by a United States District Court judge, acting in the absence of a jury.<sup>9</sup>

Table 2 indicates the injury coding available for 3,771 reports. Alleged injuries were related to surgery, diagnosis, and treatment in 30 percent, 26 percent and 23 percent of that total, respectively. This is similar to the experience of St. Paul Fire and Marine Insurance Company, one of the nation's largest private carriers of medical professional liability insurance.<sup>10</sup> Their report concerned 7,233 claims filed against insured physicians in 1989 and 1990. Alleged injuries were related to surgery, diagnosis and treatment in 25 percent, 27 percent, and 27 percent of those claims, respectively.

District Counsel offices submitted reports regarding severity of injury in 3,719 claims, as indicated in Table 3. The injury was death in 32 percent of reports. Permanent significant injury or permanent major injury constituted 18 percent and 14 percent of the total, respectively. These figures would appear to suggest that patients who experience relatively severe adverse clinical outcomes are more likely to file claims.

Table 4 regards the location within a treatment facility where alleged negligence occurred. Twenty-seven percent of cases occurred in the operating suite, 19 percent in patients' rooms, and 22 percent either in the outpatient clinic or emergency/admitting department. St. Paul reported that 34 percent of their claims occurred in the insured physician's office or clinic while 64 percent arose in the hospital and 27 percent in surgery.<sup>11</sup>

Table 5 (next page) reports the hospital service where the alleged negligence occurred. Of the 3,994 entries, medicine constituted 31 percent and surgery 32 percent. Seven percent (266 cases) occurred in ambulatory care.

Table 6 (next page) reflects specialty determinations within the reports of the District Counsel offices. A weakness regarding this entry was that only a single specialty could be reported when, in many cases, there may have been several specialties involved. Certain general trends, however, can be detected. Orthopedic surgery accounted for 157 (13 percent) of these entries. Internal medicine and general surgery each accounted for approximately 10 percent, while psychiatry accounted for 9 percent. Other specialties were represented less frequently. Specialty areas may well deserve more attention in any future studies.

### ALLEGED INJURY

ALLEGED INJURY	NUMBER	PERCENT
Surgery Related	1136	30
Diagnosis Related	962	26
Treatment Related	871	23
Medication Related	356	9
Other	324	9
Suicide	89	2
Homicide	33	1
<b>TOTAL</b>	<b>3771</b>	<b>100</b>

TABLE 2

### INJURY SEVERITY

INJURY SEVERITY	NUMBER	PERCENT
Death	1202	32
Permanent Significant	696	18
Permanent Major	524	14
Temporary Minor	324	9
Temporary Major	291	8
Permanent Minor	251	7
Emotional Only	108	3
Other	90	2
Temporary Insignificant	65	2
Grave	61	2
No Injury	58	2
Legal Issue Only	49	1
<b>TOTAL</b>	<b>3719</b>	<b>100</b>

TABLE 3

### LOCATION OF ALLEGED NEGLIGENCE

LOCATION	NUMBER	PERCENT
Operating Suite	1036	27
Other	797	21
Patient's Room	726	19
Outpatient Area	528	14
Emergency/Admitting Area	318	8
Special Procedure Room	157	4
Radiology	120	3
Intensive Care	101	3
Recovery	24	1
Physical Therapy	17	<1
<b>TOTAL</b>	<b>3824</b>	<b>100</b>

TABLE 4

HOSPITAL SERVICE		
SERVICE	NUMBER	PERCENT
Surgical	1262	32
Medical	1233	31
Psychiatry	314	8
Ambulatory Care	266	7
Other	215	5
Nursing	146	4
Radiology	105	3
Neurology	65	2
Ophthalmology	48	1
Dental	44	1
Laboratory	44	1
Oncology	44	1
Pharmacy	44	1
Administration	39	<1
Rehabilitation Medicine	21	<1
Spinal Cord Injury	21	<1
Psychology	17	<1
Engineering/Bldg. Management	16	<1
Podiatry	16	<1
Nuclear Medicine	8	<1
Dietetic	6	<1
Research	6	<1
Audiology/Speech Pathology	3	<1
Chaplain	3	<1
Social Work	3	<1
Voluntary	3	<1
Recreation	2	<1
<b>TOTAL</b>	<b>3994</b>	<b>100</b>

**TABLE 5**

Table 7 (next page) indicates the type of medical negligence alleged in 1,574 cases. Errors in diagnosis and improper surgical/medical procedures each constitute 25 percent of this total. Allegations regarding defects in planning or executing treatment occurred in 336 or 21 percent of the cases reported.

### TCIS TODAY

TCIS has recently undergone a major revision. Coding changes have been applied to a number of the data collection elements, and additional elements have been added for the reports of the District Counsel offices. There have also been changes in the sections for provider information and peer review determinations. Additionally, DLM will now review every malpractice claim brought against the VA, collect additional data and integrate it with the existing matrix.

PROVIDER SPECIALTY		
SPECIALTY	NUMBER	PERCENT
Orthopedic Surgery	157	13
Internal Medicine	125	10
General Surgery	123	10
Psychiatry	114	9
Cardiology	90	7
Cardiothoracic Surgery	63	5
Neurosurgery	48	4
Otorhinolaryngology	46	4
Radiology	46	4
Neurology	42	3
Peripheral-Vascular Surgery	40	3
Oncology	39	3
Urology	39	3
Gastroenterology	36	3
Outpatient/ER	24	2
Nursing	24	2
Ophthalmology	23	2
Pulmonary	22	2
Pharmacy	17	1
Dermatology	12	<1
Podiatry	11	<1
Plastic Surgery	10	<1
Pathology/Laboratory	9	<1
Rehab. Medicine/Physical Therapy	9	<1
Oral Surgery	9	<1
Employee Health/Evaluation Clinic/ Rating Exam	9	<1
Nephrology	7	<1
Psychology	7	<1
Rheumatology	5	<1
Anesthesiology	5	<1
Hematology	4	<1
Infectious Disease	4	<1
Radiation Therapy	4	<1
Dentistry	3	<1
Endocrinology	3	<1
Gynecology	3	<1
Colorectal	3	<1
Optometry	3	<1
Geriatrics	2	<1
Renal Transplant	2	<1
Administrative	2	<1
Social Work	1	<1
Supply	1	<1
Dietetic	1	<1
<b>TOTAL</b>	<b>1247</b>	<b>100</b>

**TABLE 6**

Since the revision, when an administrative malpractice claim is received, the District Counsel office enters initial information taken primarily from the claim form alone. Within 30 days, the reporting District Counsel

### TYPES OF ALLEGED NEGLIGENCE

TYPES	NUMBER	PERCENT
Diagnostic Errors	395	25
Misadventures in Surgical/ Medical Procedures	386	25
Treatment Error or Misadven- ture in Planning Treatment	336	21
Other Events	306	19
Adverse Effects of Drugs	<u>151</u>	<u>10</u>
<b>TOTAL</b>	<b>1574</b>	<b>100</b>

**TABLE 7**

Provider Information and Peer Review Form to the District Counsel office. Regional VA offices submit medical records and the Provider Information and Peer Review Form to DLM. If, at the regional level, any additional peer reviews are conducted, these will similarly be forwarded.

Upon closure of an administrative claim by payment or by denial with no ensuing litigation, the District Counsel office sends DLM any medical expert interviews, witness statements, and an updated TCIS printout regarding the claim. Similar entries are filed by either the District Counsel offices or the VA General Counsel regarding those cases that proceed to litigation. DLM reviews the submitted information as received and submits clinical corrections where indicated. DLM also creates a separate database from entries in the Provider Information and Peer Review Forms. Annual reports are submitted to the VA Associate Chief Medical Director for Quality Management each January with regard to data collected the prior fiscal year. Quarterly reports to the VA regions are planned, along with periodic administrative submissions to the VA Associate Chief Medical Director for Quality Management. Additionally, "Open File", a continuing medical education publication of DLM regarding clinical risk management, is furnished to all VA facilities for full-time physicians and quality management coordinators.

The TCIS data collection form has been modified to facilitate the acquisition of complete data and its subsequent analysis. With the new form, a total of three hospital services and three medical specialties involved in a case can be reported. The codes for alleged negligence have been changed, and a number of medical specialties have been added to the database. The Act or Omission Code of the Harvard Risk Management Foundation will be utilized, as adopted within the National Practitioner Data Bank. Codes for alleged injury were also modified to reflect severity coding systems employed in other quality assurance programs.

A new Provider Information and Peer Review Form has been developed to replace the prior document. This new form is considered privileged and confidential, by statutory exemption, and therefore not subject to disclosure to third parties. Under the provider information section, up to three providers can be designated with their position, service and status. The peer review section has also been modified to provide information concerning specific components of care, such as diagnosis and treatment, as well as monitoring of the patient. DLM will review all materials and then collect additional data elements which will comprise the Tort Claim Analysis System. The specifics of each malpractice case, as stated above, are reviewed, pertinent information extracted and data entered into an automated database. A coding system to designate the presenting symptom has been created, and up to five presenting symptoms or complaints can be added to this system. The working diagnoses, as well as the final diagnoses, are also collected using the ICD-9 clinical modification three-digit code system. Similarly, the disease process is recorded, and up to four diagnoses and four disease processes can be included.

The area of practice or specialty is also collected, as well as the organ system involved. Up to four organ systems and four specialties or areas of practice can be collected on the same case.

An additional coding system for procedures involved in medical malpractice cases has been developed, and up to three procedures can be entered into the database. A medical injury taxonomy has been devised so that the specific injuries can be cataloged as subsets of cases. In addition, conclusions of both government and plaintiff experts are collated. If the health care provider's opinion is provided, this is also entered into the database, which concludes with the judicial opinion in those cases that end with judgment for either the plaintiff or defense.

Various risk management issues can be identified through case review. These diverse issues include the completeness of the medical record, communication problems among the staff and with patients, problems with resident supervision, autopsy issues, laboratory errors, patient follow-up problems, staffing problems, and the failure to consult specialists. Finally, a case synopsis is created in a memo field. This synopsis includes the facts, allegations, alleged errors and related patient injuries, along with the outcome of the case.

This system should be useful for VA post-graduate educational purposes aimed at identifying high risk practice areas and facilitating quality improvement efforts. Analysis of the data will be performed by both VA officials (Office of the Associate Chief Medical Director for Quality Management) and the DLM staff. This data will be used to assist other VA quality improvement programs, such as the Patient Incident Review System.

Improving TCIS represents a significant achievement. This has been accomplished through the efforts of many VA officials, both at the central and regional offices, who appreciate the unique aspects of their agency and its mission. With these improvements, information derived from TCIS and the Tort Claim Analysis System will augment the existing VA program for quality management. The targeting of preventable sources of medical negligence should ultimately improve delivery of medical care to the veteran.

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